ABSTRACT

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THE STUDY OF LATENCY AGED BOYS DIAGNOSED WITH ATTENTION-DEFICIT HYPERACTIVITY DISORDER AND THE EFFECTIVENESS OF PLAY THERAPY

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The objective of this study was to identify the effectiveness of play therapy on a latency diagnosed child with Attention-Deficit Hyperactivity Disorder(ADHD). In order to attain this objective, the following areas were addressed (a) a definition for ADHD, (b) history of ADHD, (c) emotional and mental difficulties for ADHD children (d) why the latency stage is an imperative age in diagnosis, (e) common interventions, and (f) effectiveness of play therapy in shaping behavior. The single systems design was used to determine if play therapy was beneficial to an ADHD child in long term mental health facility. One latency ADHD child residing in Charter, a longer term mental health facility, was selected to represent the target population.

THE STUDY OF LATENCY AGED BOYS DIAGNOSED WITH ATTENTION-DEFICIT HYPERACTIVITY DISORDER AND THE EFFECTIVENESS OF PLAY THERAPY

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Acknowledgments

This paper has been dedicated to my mother Irene Brandon for her continued words of motivation and endless support. For my entire life you have been my role model and my best friend, I owe you so much. A thank you to my editor Mrs. Chainey for her patient and endless hours of comfort. A special thanks to my advisor Dr. Sandra Foster for her positive words and understanding.

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CHAPTER 1

INTRODUCTION

"Johnny, Johnny, could you please sit down and not jump on your chair! Class is still in session and it's not time for recess yet." "Johnny, could you please pay attention to today's math lesson on the chalk board and not daydream". "Johnny, please take a time out for hitting Elma in the jaw".

This type of scenario is reenacted every day between eight-year-old Johnny and his teacher because, like thousands of other elementary school-aged children, Johnny suffers from Attention-Deficit Hyperactivity Disorder (ADHD). The diagnosis of ADHD is more likely to occur during this latency period, a stage of personality development beginning from about the age of seven and ending around the beginning of the pre-teen years. It is a time when children's behaviors are observed outside of home in a school setting that requires them to adapt to certain rules and regulations. The symptoms of ADHD are: inattentiveness, hyperactivity, impulsiveness, inappropriate behavior, fighting and an inability to complete assigned tasks.

Research shows that ADHD is found more frequently in males, and that there are numerous causes for its existence. Low birth rate, lack of oxygen to the brain, a difficult child birth, lead poisoning, lack of vitamins, an allergic reaction to foods, a traumatic childhood experience, head injuries, and heredity are just a few of the things that can cause ADHD[1]. In home and school settings,

[1] Larry B. Silver M.D. Dr. Larry Silvers Advice to Parents on Attention-Deficit Hyperactivity Disorder. American Psychiatric Press, Inc. (Washington, 1993),88.

ADHD children show symptoms of having difficulty sitting, waiting their turn, raising their hand, using appropriate language, keeping their hands and feet to themselves and acting out.[2] In fact, ADHD seems to actually manifest itself as impatience. Behavior manifestations usually appear in a multiple of contexts, including home, school, peer interaction and social settings. For latency children to be diagnosed with this disorder, they must exhibit behaviors in school, home and social settings for six months or longer.[3] As time progresses, symptoms usually worsen in situations that require the child to have sustained attention, mental effort, or intrinsic appeal.[4] In the area of peer and social interaction, children with ADHD do not communicate or relate well to their peers. Research has shown that the long-term outcome of ADHD may lead to occupational difficulties, alcoholism, psychiatric disorders and possibly anti-social behaviors.[5]

Research shows ADHD has also impacted academic success. Many children are not able to be retained in an average classroom. Instead, they are placed in Learning Disability, Special Learning Disability, Emotionally Handicapped and other below-academic-level functioning programs. The combination of inappropriate behavior in the classroom, frequent corrections by the teacher, and poor academic performance leads other students to consider

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[2] DSM IV American Psychiatric Association: Fourth Edition. Published by the American Psychiatric Association. (Washington, D.C., 1994), 79.

[3] Ibid.

[4] Larry B. Silver M.D. Dr. Larry Silvers Advice to Parents on Attention-Deficit Hyperactivity Disorder. American Psychiatric Press, Inc. (Washington, 1993),88.

[5] Ibid.

these children as dumb. Consequently, there is an increase in the amount of peer rejection which leads to low self-esteem.[6]

In many cases, children who suffer from ADHD must take medications to help control their behavior, and to help them think clearer. Even though teachers and parents are grateful for these medications, studies have shown that prescriptions are written too quickly before an accurate assessment is completed. Some of the popular medications used to treat ADHD are: methylphenidate, ritalin, clondine, catapres, amphetamines, dexedrine, pemoine, tofranil, zoloft, and xanax. Each medication carries a possibility of three or more side effects including death in high dosages. Instead of only administering medication as an intervention, play therapy (a form of therapy where the child plays through situations) can be used to help children in situations that require them to remain quiet and attentive for long periods of time. In play therapy children learn to role play and formulate methods of appropriately interacting. Some consider it as a dress rehearsal in which the child plays through difficult situations. Play therapy has proven to be very effective in helping ADHD children develop their cognitive skills, their strengths and to identify their weaknesses. It also helps the child develop positive ways to vent and work out feelings of frustrations.[7]

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[6] Ibid.

[7] JoAnna White and Christopher T. Allers. Play Therapy with abused Children. Journal of Counseling and Development March/April volume 72. 1994,390.

Statement of the Problem

Attention-Deficit Hyperactivity Disorder is an area in which insufficient attention has been given for looking at the implementation of not only medication; but play therapy (for when a child plays he works out feelings or frustrations)[8].

Significance of the Study

From the increased diagnosis of ADHD in children, there is an increasing demand to significantly inform the public of other methods of treating these children, besides the use of medication therapy. Without sufficient attention given to this area, there will be more children forced to take drugs in order to think clearer or remain calm. If adults encourage the use of drugs, then what type of message is this sending to these ADHD-diagnosed children? The child may be taught that by taking a pill, his or her problem will be fixed. Some of the side effects include short- and long-term seizure disorders, dependence on medications, overdoses, stunting of growth, heart problems, kidney problems, eating disorders, skin disorders, rashes, blurred vision, uncontrolled movements of the body (tics) and the list continues. By using play therapy as a natural method of therapy the child has an alternative that has been proven to be effective. By using play therapy, the child is able to see progress and be able to

[8] White, JoAnna and Christopher T. Allers. Play Therapy with abused children. Journal of Counseling and Development. March/April. Vol. 72.1994, 390.

use the therapy at times when he/she feels unfocused or desires to role play through a situation. Through the use of play therapy, the ADHD children of the world will be able to lead more productive and healthy lives.

Purpose of the Study

The objective of this study is to identify the effectiveness of play therapy on a latency child diagnosed with ADHD. Through play therapy the child learns the natural way to vent his/her anger, to role play through difficult situations, and to learn to communicate with adults through play. Play therapy not only works on venting anger, but helps the child develop cognitive skills that will help him or her remember such things as stop and think. Play therapy is a very healthy way for children to work through life's problems on their own. It is important that social workers become aware of this method of treatment so that they can offer it to the children, as an alternative to medication, thus eliminating the side effects caused by these medications.

CHAPTER 2

REVIEW OF THE LITERATURE

The literature review will provide a clear understanding of Attention-Deficit Hyperactivity Disorder in latency- aged children and the effectiveness of play therapy. The following areas will be addressed by the researcher :1) Attention-Deficit Hyperactivity Disorder overview, 2) latency stage, 3) different difficulties, and 4) play therapy as the intervention. Part I will provide a clear definition and understanding of ADHD. Part II will provide information related to why the latency stage was chosen to observe, along with current difficulties. Part III will provide information of the different forms of play therapy and how it has been effective with this population.

Attention-Deficit Hyperactivity Disorder

In discussing the topic of this research, Attention-Deficit Hyperactivity Disorder the first question that must be answered is What is Attention-Deficit Hyperactivity Disorder? Robert J. Campbell, M.D., in the Psychiatric Dictionary defines it as "symptoms including inattention, excessive motor activity, and impulsivity".[1] The author feels that the "hyperactivity of the disorder is manifested in restlessness and poorly organized excess activity that is a hazard, inconsistent, and lacking clear goal orientation".[2] The syndrome appears early in

[1] Robert Jean Campbell M.D. Psychiatric Dictionary. Seventh Edition. Oxford University Press. (New York,1996),72.
[2] Ibid.

life (in infancy or by the age of seven years), is more common among boys, and may occur in as many as 3 percent of prepubertal children.[3]

Papalia and Olds (1986), authors of A Child's World Infancy Through Adolescence, define this same term as a "syndrome characterized by inattention, impulsivity and considerable activity at inappropriate times and in inappropriate places".[4] These authors state that these traits appear to some degree in all children at one time or another. "In about 3 percent of school-aged children (10 times more boys than girls), they are so pervasive that they interfere with the child's functioning in school and other aspects of daily life".[5]

Yet Zanden (1993) says that children who have short attention span, exhibit sleep problems, throw temper tantrums and have difficulty learning to sit still, or respond to discipline suffer with ADHD.[6] He goes further to share that these youngsters basically have problems getting things done at home and school and have trouble getting along with peers and adults.

What is Hyperactivity and how is it correlated to Attention-Deficit Hyperactivity Disorder?

To have a true understanding of ADHD, it is imperative to define hyperactivity and the role it plays in the life of an ADHD child. Without hyperactivity, ADHD would only exist as Attention-Deficit Disorder (ADD), which

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[3] Ibid.

[4] Diane E. Papila and Sally Wendkos Olds. A Child's World Infancy through Adolescence. Fourth Edition. Mc Graw-Hill Book Co. (New York, 1986),447.

[5] Ibid.

[6] James W. Vander Zanden. Human Development. Fifth Edition. Mc Grae-Hill, Inc. (New York, 1993),337.

is similar yet different from the disorder discussed here. An important question that researchers should ask themselves is what is hyperactivity? It is defined as a "mental disorder in children marked by a chronic tendency to be excessively active, lack control, and be unable to concentrate".[7] Hyperactivity is a disorder that compares children's behavior to being driven by a motor constantly. Hyperactivity manifests itself in behaviors of "showing inappropriate inattention and impulsivity".[8] These children may run around and climb on things excessively, they may need to be re-directed to focus on task, have difficulty sitting, fidget a great deal, or move about more than would be expected even during sleep.

It is assumed that possibly the child's body produces too much adrenaline for daily activities. Hyperactive children are unable to sleep for long periods of time, complete numerous tasks at one time, exhibit patience, or interact appropriately without re-direction to focus back on what they were originally doing. "A close examination of the brain shows reduced activity in the regions of the brain responsible for motor activity and attention".[9] This may explain why the child's body produces such a large quantity of adrenaline; because there is a void in this specific region of the brain where it assumes the child needs more energy.

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[7] John P. Dworetzsky. Introduction to Child Development. 5th edition., West Publishing Company. (New York, 1993),447.

[8] Ibid.

[9] Ibid.

Hyperactivity is a mental disorder that is becoming increasingly more popular where there is a heredity connection, a learning disability, and an exertion of energy especially in boys. Through research, hyperactivity no longer exists without being connected with Attention-Deficit Hyperactivity Disorder. They are correlated because children now show more symptoms related to impulsivity, inattention, learning disabilities and hyperactivity. These just listed are the major behavior indicators identified to diagnosis a child as ADHD.

History

The history of ADHD goes as far back as the 1980's, but the name has changed many times between then and now; hyperactivity is identified as the better term to be traced. According to records "hyperactivity was first described in 1845 by Henrich Hoffman, a German Pediatrician".[10] Through time the diagnostic label for hyperactivity has been changed repeatedly, with terms such as hyperkinesis, hyperactive-impulsive disorder, minimal brain damage, minimal brain dysfunction, Strauss Leitinen Syndrome, and Attention-Deficit Hyperactivity Disorder.[11]

From its founding until the present, hyperactivity is steadily on the increase in boys. Research supports the fact that boys are affected more often than girls, by a ratio of about three or four to one.[12] In fact, hyperactive children

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[10] The Encyclopedia American International Edition. Groiler Incorporated. (Connecticut, 1994). Volume 14, 675.
[11] Ibid.
[12] Ibid.

are noted as accomplishing amazing infant milestones in the infancy stage much faster. For example, a hyperactive child may begin scooting a month or more before other non-hyperactive children. Over the years there has been, such a constant change in diagnosis, name and criteria many researchers have challenged the diagnosis validity and reliability. Historically, hyperactive children have the most difficulty in the areas of attention, concentration and impulse control.

Dr. Barbara Ingersoll in her book Your Hyperactive Child: *A Parents Guide to Coping with Attention Deficit Disorder* supports earlier history, but adds that the confusion has been compounded by the bewildering variety of terms used over the years to describe the condition. For example, the condition has been referred to as minimal brain damage or minimal brain dysfunction, hyperkinesis, hyperkinetic reaction, and hyperactivity.[13] She feels that the changes in the terminology changed the outlook of the diagnosis. From the incorporation of the term minimal brain damage, came the usage of terms such as hyperkinetic and hyperactive, which eventually led to the term of ADHD. Ingersoll suspects a link between brain damage and hyperactive behavior was strengthened by the 1918 encephalitis epidemic; this was actually when doctors observed that many children developed this behavior pattern following recovery from encephalitis.[14]

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[13] Barbara Ingersoll Ph.D. Your Hyperactive Child *A Parents Guide to Coping with ADD*. Doubleday. (New York, 1988),3.

[14] Ibid.

Ingersoll identified psychologists Virginia Douglas at McGill University in the 1970's as the first individual to study the attention span, impulsiveness and inability to stop, look and listen before acting.[15] Ingersoll identified the DSM III (1987) edition of guidelines in her book, for the term ADHD. According to the DSM III in order for a child to be diagnosed with ADHD they must first exhibit behaviors for six months or more in at least eight of the identified behaviors. The behaviors are identified as: (1) fidgeting with hands or feet or squirming in seat (2) having difficulty remaining seated when required to (3) becoming easily distracted by extraneous stimuli (4) having difficulty awaiting turn in games or group situations (5) blurting out answers to questions before they have been completed (6) having difficulty following through on instructions from others (7) having difficulty sustaining attention in tasks or play activities (8) shifting from one uncompleted activity to another (9) having difficulty playing quietly (10) talking excessively (11) interrupting or intruding on others (12) not listening to what is being said to him or her (13) losing things necessary for tasks or activities at school or at home and (14) engaging in physically dangerous activities without considering possible consequences. These symptoms usually have an onset before the age of seven. Ingersoll feels although most professionals agree on the guidelines that have been specified, important insights have been overlooked.[16]

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[15] Ibid. p.4.
[16] Ibid. p. 6.

Taylor (1990) shares another perspective, that ADHD is a difficult diagnosis because it tends to appear gradually. "Neurological and physiological studies indicate that ADHD sufferers have a wide range of biochemical imbalance and uniqueness".[17] Taylor also feels that the symptoms change in various settings. One of the most difficult aspects of this disorder is deciding how much of the unusual behavior is normal.

Causes

According to Taylor (1990) research has shed some light on hyperactivity and attention deficits from the fetal stage to age six.[18] Most of the characteristics that will be described are associated with a greater chance than normal likelihood of the syndrome, but no ADHD child has all these indicators, and many of the symptoms occur in non-ADHD children. The fetal indicators are usually increased when an expecting mother is sitting or lying quietly, have poor maternal health, a mother under the age of 20 years old, a first pregnancy, an infection resulting in elevated blood pressure and circulation of toxins in the mothers bloodstream, the mother having convulsions in the latter part of her pregnancy, maternal substance abuse, and heavy maternal smoking.[19] The birth indicators are: lack of oxygen, labor lasting more than thirteen hours, gestation of ten months or longer, any type of birth injuries, physical malformations, fetal

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[17] John F. Taylor PhD. Helping your Hyperactive Child. Prima Publishing and Communications. (Rocklin, CA,1990),27.

[18] Ibid. p. 27.

[19] Ibid. p. 27-28.

alcohol syndrome, prematurity, low fetal heart rate during the second stage of labor, low placental weight, breech presentation, and inflammation of the outmost of two membranes enveloping the preborn child.[20]

In his book Taylor also identified the early infancy indicators as inadequate sleep, irritability, excessive crying, feeding problems, health problems (allergies, colds, asthma, respiratory infection, fluid in the ears), and poor bonding. This is where the baby isn't cuddly or responsive and is restless and has much difficulty managing through such activities as bathing, diaper changing, or feeding. Taylor identified the late infancy indicators (6-18 months) as: unusual crib behavior such as for thumping, excessive rocking, head banging, and climbing out of the crib, rapid or delayed development of physical skills such as, crawling, sitting, standing, walking, and running, delayed or rapid development of verbal skills, low adaptability to change, and sleep difficulties.[21] The indicators of hyperactivity in toddlers are: aggressiveness, destructiveness, overactivity, incorrigibility and recklessness.[22] In the preschool stage he identifies stomach problems, lack of coordination in small muscle groups, off-task behavior, overactivity, intrusiveness, aggressiveness, distractibility and parent-child conflict.[23]

Ingersoll follows Taylor and identifies many of the exact areas of cause that Taylor does. She went a step further and included the environment as one

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[20] Ibid. p. 28-29.
[21] Ibid. p. 29-30.
[22] Ibid. p. 30.
[23] Ibid. p. 30-31.

of the causes. Ingresoll states in her book that the potential sources of damage include a great number of hazardous substances in our environment Asbestos, foam insulation, toxic wastes dumped into rivers, leaking from underground storage tanks, and high levels of pollutants in the air are all known to pose serious hazards to our health.[24] The effects of lead poisoning have long been known, and lead poisoning has been suggested by many, as a possible cause of ADHD. In addition, pallor, irritability, nausea, and loss of appetite,are symptoms of lead poisoning that have been found in neurological damage and psychological problems.

In Ingersoll's book she identified Dr. Benjamin Feingold, a pediatrician and allergist, as the first to draw widespread attention to the idea that food dyes and additives might cause ADHD and other behavior disorders In fact, Dr. Feingold speculated that allergy like reactions to certain foods and food additives cause about half of the cases of ADHD in this country.[25] In addition to synthetic dyes and flavoring, Dr. Feingold believed that intolerance to salicylates, an acidic substance found in aspirin and many fruits and vegetables, could also result in behavioral disturbances.[26]

Not only has the environment and additives been analyzed, but research has also proven to be promising in the area of brain biochemistry. "The fact that certain kinds of stimulants can produce marked changes in the behavior of

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[24] Barbara Ingersoll Ph.D. Your Hyperactive Child A Parents Guide to Coping with ADD. Doubleday. (New York, 1988),31.

[25] Ibid.

[26] Ibid.

hyperactive children has encouraged scientists to search for underlying abnormalities in neurotransmitter systems."[27] More promising approaches to this study of brain abnormalities in hyperactive children involve the techniques of brain imaging. The most familiar of these techniques is the computerized topography (CT) scan, which uses X rays to construct a computerized image of the brain; unlike traditional techniques the CT provides a very vivid image of the brain. CT scan techniques are used to detect tracers, from this, scientists can determine the amount of blood flowing through different parts of the brain.[28] "Because patients are exposed to some radiation, the use of this technique in research with children is sharply restricted in this country."[29]

Another area of cause that is being looked at is heredity. Ingersoll notes in her book that, compared with parents of other children, parents of hyperactive children are much more likely to have been hyperactive children themselves. If the child is severely hyperactive, the likelihood that one or both parents were hyperactive in their childhood may increase the chances of their children being hyperactive, according to Dr. Leopold Bellack at New York University.[30] It is stated that among the hyperactive children that Bellack examined, he found severe cases of the disorder heavy influenced by both families and their families. Siblings (especially brothers) of hyperactive children are also more likely than other children to have symptoms of ADHD: as many as one fourth of the brothers

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[27] Ibid. p. 62.
[28] Ibid.
[29] Ibid. p. 63.
[30] Ibid.

of hyperactive children have similar problems themselves. "The risk appears greatest for children who have a hyperactive twin".[31] Bellack raises the question that since many hyperactive children grow up in families in which one or more members has a psychiatric illness, does this mean that there is a hereditary component in ADHD?[32] He concluded that perhaps the child has possibly learned troublesome behavior patterns from a parental role model, as other children learn by mimicking their parents.[33]

In addition, a study was done by Joseph Biederman in 1995 entitled "High Risk for Attention Deficit Hyperactivity Disorder Among Children of Parents with Childhood Onset of the Disorder: A Pilot Study," which is complied of a national sample of adults who had ADHD. It looked at how their children are continuously being diagnosed. The results show that children of parents with ADHD were at a high risk for meeting diagnostic criteria for the disorder. In fact, 84 percent of the adults with ADHD who had children, had at least one child with the disorder, and 52 percent had two or more children with the disorder.[34]

Kenny and Fussetti in their book The Hyperactive Child Book documents that toxins could be affecting the fetus during pregnancy, and after the birth of the child. They state that alcohol consumed during pregnancy can lead to long-term effects including ADHD. Fetal Alcohol Syndrome is one of those long-term problems that not only causes ADHD, but lowers intelligence, promotes speech

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[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Biederman, Joseph MD et al; eds., High Risk for Attention Deficit Hyperactivity Disorder Among Children with Parents with Childhood Onset of Disorder: A Pilot Study. Am J Psychiatry 152:3, March 1995,433.

delays, increases poor fine-motor coordination, decreases attention and other behavioral problems.[35]

Kenny and Fussetti's research show that one of the toxins affecting kids after child birth and cause ADHD is lead poisoning. The child may receive lead poisoning from a variety of places, but normally from paint chips in the household. In combination with diagnosis, causes, and effects they advocate for testing of the brain. These tests are called the (CAT) scan, which is a computerized axial topography of the brain; and a (EEG) which is a electro-encephalorma this is where the child's hair is divided into sections and wires are placed in the child's hair, behind the ears, and on the chest. Once the testing is completed the results are read, and an accurate diagnosis is done to support or disagree with earlier findings. If in fact the child has ADHD, they state from the research that they have done, over seventy-five percent of children with ADHD can be helped through the usage of medication. Medications are used to treat the parts of the brain that aren't receiving messages from the neurotransmitters; which is a natural stimuli that sends messages back and forth in the body.

Latency

Research has identified young boys in the latency stage ages 7 through elementary school as those most likely to be affected by hyperactivity. This is because boys are more aggressive when playing than girls. This stage of

[35] Kenny, Patricia Leif and Lydia Terdall Fussetti. The Hyperactive Child Book. Peterson's Guides. St.Martin Press. (New York, 1993),18.

development is the child's first chance to interact without the presence of parents. They learn to adapt to their new environment of school.

Erickson felt this was a time in which the child develops a sense of industriousness, he begins to comprehend the world of his culture; and they can become an eager and absorbed member of that productive situation which gradually supersedes the whims of play.[36] The latency-age stage has been targeted as a time in the child's life where the behavior of a child can be more accurately diagnosed, as that of possibly ADHD and treated if need be. Research shows that during this stage the prognosis is more accurate; because the child is being observed in several settings and exhibiting the same types of behavior.

Physical Difficulties

The individual that studied the physical difficulties of Attention Deficit Hyperactivity Disorder was Taylor in his book entitled Helping Your Hyperactive Child. He identified constant movements as the first physical difficulty. He states that this trait is one of the two that define the syndrome in its narrowest sense. Taylor states that there is poor channeling of energy, with irrelevant and useless movements of various body parts, for example, they jump, fidget, squirm, rock, wiggle, and run.[37] These type of children are constantly redirected to stay

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[36] Zanden, James W. Vander. Human Development. Fifth Edition. Mc Graw-Hill, Inc. (New York, 1993),36.

[37] John F. Taylor Ph.D. Helping your Hyperactive Child. Prima Publishing and Communications. (Rocklin, CA, 1990),21.

beside their parent, they are unable to see it is dangerous to run ahead. For instance, when focusing on a television or a computer screen, they may change body positions, make taping noises or move around constantly. Repetitive behaviors such as thumb sucking, nail biting, scratching and picking at sores and fingernails, teeth grinding, or pulling out hair one strand at a time are very common with this diagnosis.

The second physical difficulty is variable rates of development. During infancy and toddler hood some ADHD children may develop faster than peers; for instance, some may learn to walk and talk earlier than other toddlers. Since these children are constantly on the move, they are far more advanced than peers their age developmentally. Occasionally, they may skip a stage in development, the most common stage skipped is learning to walk without first learning to crawl.[38] It seems strange that these children would be able to skip stages, but they are able to.

The third physical difficulty is food cravings. Here is where ADHD children may try and satisfy a profound craving for sweets by eating powdered gelatin straight from the box, large quantities of dessert at one sitting, and sugar by the spoonful. In many cases the child must be watched constantly to ensure they haven't consumed too much sugar or sweets. It has been found that in some children the more sugar and sweets they consume, the more hyper they become. The fourth physical difficulty is allergies and sensitivities. "Hyperactive children are among the most allergic, and they frequently show signs of allergy

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[38] Ibid.

to offending substances such as animal bits and stings, chemicals, medicines, pet dander and feathers, dust, mold, and cosmetics".[39] The most common food allergies among these children are to chocolate, corn and corn products, eggs, milk, nuts, pork, sugar, and wheat products.

The fifth physical difficulty is sleep problems. These children may not want to go to bed, even though they have been active throughout the day. Some ADHD children may sleep restlessly and others may experience sleep so intense that they may have nightmares, talk or walk in their sleep or wet to bed. The sixth physical difficulty is coordination problems. "Hyperactive children may have a poor sense of balance and problems with large muscle coordination".[40] Because there is a general awkwardness of movement and a clumsy gait, they may find it hard to hop on one foot, jump rope, or play any type of ball.[41]

Dr. Ingersoll, Diane Papalia and Sally Olds identify their physical symptoms as totally different compared to Taylor. These authors identified enuresis, encorpresis, tics and stuttering as the physical difficulties of ADHD children. Dr. Ingersoll states that hyperactive children continue to have problems with bladder control long past the age when most other children are dry though the day and night.[42] "Parents often search for physical causes and cures for wetting, but in only a small percentage of cases is there an obvious medical reason for the problem, such as a urinary tract infection".[43] When a

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[39] Ibid. p. 22.
[40] Ibid.
[41] Ibid.
[42] Barbara Ingersoll Ph.D. Your Hyperactive Child *A Parents Guide to Coping with ADD*. Doubleday. (New York, 1988),135.
[43] Ibid.

child is wetting their clothes during the day, several weeks of observation are needed in order to properly identify the incidents that cause the child to wet. At this point it is important not to punish the child physically, but to observe carefully to identify specific times when the child urinates on himself.

Hyperactive children may simply day wet, because they are reluctant to interrupt their play for something as mundane as going to the bathroom.[44] Ingersoll encourages the child to practice stopping and starting the stream of urine; she feels this will help strengthen the muscle that controls urination.[45] "For the hyperactive child who is in constant conflict with his environment and whose self-esteem is already low, bed wetting may seem like one more failure in a long series of failures".[46] Interventions have been but into place to help the children control their flow of urine. A dry bed training is a form of alarm system that is used to awaken the child when the pad is moistened. The alarm awakes the child or the parent and the child then goes to the bathroom.[47] In addition, to the dry bed training, there exists in some behavioral programs a medication by the name of Tofranil 10-75 mg that is used to treat the same situation.

Another form of physical symptom that is discussed by Ingersoll, Papilia and Olds is encorpresis: when the child soils their clothing. Some children pass large, fully formed stools in their pants (or in other inappropriate places).[48] Some children go as far as to play or even eat their feces. According to these

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[44] Ibid. p. 136.
[45] Ibid. p. 137.
[46] Ibid.
[47] Ibid. p. 139.
[48] Ibid. p. 141.

authors most soiling occurs in the afternoon after school, or when the child is excited; most children who soil are chronically constipated. Some children soil their clothing as a way to punish their parents, or to gain control over their feces. These are children who don't understand the importance of control or boundaries. "Prolonged stool retention or constipation results in a distended bowel (megacolon), impacted feces, and relaxed anal sphincter muscles".[49]

Tics is another physical symptom that includes repetitive, involuntary muscular movements, known as stereotyped movement disorders.[50] Children with tics may blink their eyes, hunch their shoulders, twist their necks, bob their heads, lick their lips, grimace, grunt, snort, and utter guttural or nasal sounds; about 12 to 24 percent of school children have a history of tics. An ADHD child could be sitting and their head will be bobbing without them having any control over it. The final form of physical syndrome is stuttering, defined as stammering repetitive speech. "Theories about the causes of stuttering include physical explanations such as faulty training in articulation and breathing, factors related to brain functioning and a defect in the system that provides feedback about one's own speech".[51]

Emotional Difficulties

The only author that discussed the emotional difficulties of Attention-Deficit Hyperactivity Disorder was Taylor in his book Helping Your Hyperactive

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[49] Ibid.

[50] Diane E. Papila and Sally Wendkos Olds. A Child's World Infancy through Adolescence. Fourth Edition. Mc Graw-Hill Book Co. (New York, 1986),449.

[51] Ibid.

Child. Taylor identified five emotional difficulties that exists. The first is self-centeredness; ADHD children tend to blame others and external circumstances for their difficulties rather than accepting responsibility.[52] ADHD children will very rarely take responsibility for any of their actions. For example, Johnny may have been observed by his mother playing in the mud and throwing it on the house, Johnny will deny it even though the mud is on his hands. Their own needs and desires are what matters most to them, they are not concerned with anyone else. The second difficulty is impatience. These children are typically negative, contrary, oppositional, and hard to please. For example, while standing in line, Johnny may push Christi on the floor in order to get to the play ground faster. Johnny is not concerned that he pushed Christi down, but that he is at the front of the line, and the first to go onto the play ground. This not only happens at school, it could happen while playing sports with peers. They maintain the same thought pattern of selfishness. Although Johnny knows he has team mates, he may never allow them to make a score throughout the entire game.

The third emotional difficulty is recklessness. It has been shown that these children make constant errors. They make constant errors because they are concerned about finishing first, not if the work is correct or not. They make careless errors, where if they had taken the time they would excel as superior students. ADHD children have no fear of heights, strangers, animals, water,

[52] John F. Taylor Ph.D. Helping your Hyperactive Child. Prima Publishing and Communications. (Rocklin, CA ,1990),24.

traveling alone, or wandering away from home. These children are easily dared by peers to do things just because. They only think of the moment, they don't take time out to think of the consequences. These children may walk up to a strange animal and pet it, or go as far as to pop its neck. These type children will jump into a pond and know they can't swim. They may jump off a swing while it is still swinging, fall on the ground and try it again.

The fourth emotional difficulty is extreme emotionalism. This is a lack of restraint or cushioning of their emotions, rapid mood changes, and extreme excitability, which often are expressed in raw, overwhelming, and extreme form, are characteristics of hyperactive children. They are irritable, easily upset, and react angrily to structure, or provoking. They are moody, impulsive and unpredictable, quick to forgive and forget: angry one moment and happy the next. These children are fun and loving at one time and destructive in another time. The fifth symptom is weak conscience. "Many ADHD children have poor respect for invisible boundaries such as: property, borrowing without permission, stealing trinkets and candy from stores and money from family members, invading purses and drawers of parents and siblings, and failing to return items they have borrowed".[53] Living space is another area that ADHD children have weak consciences in. "They enter without knocking, sneak into siblings' bedroom, and interrupt others in the bathroom".[54] Privacy is yet another area where these children have problems. Limits and poor body space are other

[53] Ibid.
[54] Ibid.

problem areas. For example, they may pound on the door and repeatedly ring the doorbell while waiting to enter, badger and demand explanations when given an undesirable answer, speak too loudly, stand too close, poke and grab, tickle or hit, and taking things from others without permission.[55]

Mental Difficulties

Mental difficulties is an area that is covered only by Taylor. The first mental difficulty is distractibility. ADHD children have a lot of difficulty blocking out excess noises, in order to concentrate on what they are suppose to be doing. "ADHD suffers are poor at focusing concentration, channeling effort, and saving energy for useful purposes".[56] If they are in a classroom and the teacher is teaching and a truck is passing on the highway at the same time, the child cannot block out the noise of the truck. This is also a problem when more than one person is talking to a child at a time. They are only going to understand bits and pieces, if anything at all. Confusion is another form of mental difficulty that is a challenge for these children. ADHD children have trouble recognizing an object that stands out the background, perceiving both as a blurred picture. "These children have trouble organizing and arranging schoolwork; for example, they may be tempted to go skateboarding on the night before an important exam".[57] Faulty abstract thinking is where these children have difficulty restating a sentence or paragraph in different words, their note-taking is often inept, and

[55] Ibid. p. 27.
[56] Ibid. p. 14.
[57] Ibid. p. 15.

they have difficulty understanding what they have read. "Because these children are especially weak in social situations involving abstract concepts, they interpret the teacher's reminder to sit still and stop bothering nearby students as a personal insult that has no basis other than the teacher is picking on me".[58]

Inflexibility is a major area that ADHD children show a lack. They have trouble adjusting to change and adapting without a lot of confusion. As long as things remain the same or are structured, they normally do well. Poor verbal skills is another category that ADHD children have problems. They may stutter or speak slowly as a way to verbally express their thoughts. Though they might understand some concepts, they still do poorly on tests because of their inability to connect their thoughts. ADHD children are also aimless, as these children appear inconsistent and unpredictable.[59] They never have a direction that they're trying to follow—they wander around. These children lead disjointed, chaotic lives, and seem unable to accommodate or change to the needs of others. These children also have perceptual difficulties; for example, they may have problems putting on clothes or straightening their room.

The final mental difficulty identified by Taylor is their inattention to body states. These children have poor perception of body boundaries. These children will hug without permission, and not know that they are breaking your boundaries. They have no concept of being five or more feet away from anyone when speaking to them. They seem to be insensitive to pain; they might injure

[58] Ibid. p. 17.
[59] Ibid. p. 18.

themselves severely, then fail to report the injury. For example, they might not feel hunger even though not having eaten for an entire day.[60]

Severity of Attention Deficit Hyperactivity Disorder Diagnosis

The severity is another area that is covered by Taylor in his book. Borderline and mildly hyperactive children, scoring 25 to 32 on the Taylor Hyperactivity Screening Checklist tend as a group to show somewhat different behavior.[61] In order to be ranked in the high severity range of this scale the patient must show symptoms of: showing symptoms in different settings, require high dosages of medications, show sensitivities to many environmental irritants and chemicals, be allergic to foods, pollens, animal dander, mold, dust, or medicines, have noticeable symptoms before age two, have increasing or consistent ADHD symptoms during adolescence, have many symptoms as an adult, have many cognitive impairments, show severe behavior disturbance, benefit little from counseling, be aggressive toward others, and be enrolled in special education programs.

According to Taylor the less severe the child, the lower their score will be according to the checklist. A low-range child will show variation in ADHD symptoms in different settings, respond to lower dosages of medication, tolerate exposure to some environmental irritants and chemicals, have no allergies, appear symptom-free until age two, show symptoms at a constant level or decreasingly from age three to adolescence, experience decrease in many

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[60] Ibid.

[61] John F. Taylor Ph.D. Helping your Hyperactive Child. Prima Publishing and Communications. (Rocklin, CA ,1990),44.

symptoms during adolescence, have few or no symptoms as an adult, have few cognitive impairments, show little behavior disturbance, benefit from counseling, get along with other children and remain in regular classroom settings.

School and Special Needs

According to Taylor, prior to the late 1940's, ADHD children were considered as being mentally retarded, unteachable and suitable only for custodial educational services. "In the 1950's and 1960's, ADHD children were considered learning disabled and developmentally delayed in the physiological systems necessary for learning".[62] In 1975, Public Law 94-142 was passed to guarantee equal education to all children; school programs for these ADHD children range to meet their special needs.[63] Their overall school performance is poor; for the most part they have learning disabilities, and are at risk for retention and academic problems in the long run. "Their difficulties tend to cluster around mental confusion factors, such as difficulty concentrating and finishing a task, poor organization of school work, daydreaming, inattention, problems following instructions, absentmindedness and forgetfulness, drowsiness and slow moving".[64]

According to Taylor about 10 million school-age children in the United States have a form of learning disability. "Learning disabilities affect more boys than girls, and these children often have a history of complications during

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[62] Ibid.
[63] Ibid.
[64] Ibid. p. 254.

pregnancy or delivery, head injury, infection, or exposure to toxins".[65] Research shows a high parallel between ADHD and learning disabilities that stem from similar biochemical imbalances within the brain. The research points to an overlapping occurrence of learning disabilities and ADHD as high as 30%; and an estimation of one-third of those children-roughly 10% of the school population having the diagnosis ADHD.[66] Among these children diagnosed ADHD over the majority are considered as underachieving in school.

The following are the most common areas of academic difficulty for ADHD children: reading (understanding words, comprehending printed letters, letter combinations, reading words correctly), math (doing calculations, placing decimals, square root, negative numbers, keeping rows and columns of numbers separate), writing (writing in cursive or printing), attention focusing (blocking out distractions, avoiding daydreaming, persisting in tasks), thought processing (understanding, organizing, symbolizing, remembering), visual memory (remembering what something looks like), organization (sequencing, selecting important information, classifying information, labeling), prioritizing (selecting the main idea, listening, writing, getting the main idea, drawing a conclusion), bridging (remembering more than two events at once, understanding similarities), encoding (selecting the correct words to express ideas, producing concepts and statements), decoding (understanding what is read, comparing words, understanding marking at the ending of sentences), neatness (having

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[65] Ibid.
[66] Ibid.

neat hand writing, keeping math columns vertical, no smudges on papers), recall (remembering isolated facts, names, or dates especially with math, science, history and foreign languages), spatial relationships (knowing left from right), relationships between sounds (listening, difficulty with sound blending, remembering sounds), perceptual-motor coordination (awareness of body time, fine motor and gross motor coordination, eye hand coordination, motor performance skills) and selective attention (distinguishing between important and unimportant facts).[67]

When tested the ADHD children and adults actually had higher rates of school failure that was significantly greater than that among non-ADHD siblings. Within this study there is a constant need for tutoring, placement of special classes geared towards one-on-one attention, and repeated grades if deemed necessary. Another author by the name of Dr. K. Daniel O'Leary supports this study and states there is a possibility that between fifty and seventy-five percent of kids with hyperactivity are at least one full year behind their peers academically. [68] In all cases they are behind academically; because of their inability to stay focused on task.

Treatment Techniques

In order to be effective, a treatment program for an ADHD child must be an individualized intervention. The reasoning behind this is that each child has special needs, and may require a combination of interventions. Throughout the

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[67] Ibid. p. 259-262.

[68] O'Leary, Daniel K. Ph.D. .Mommy, I Can't Sit Still Coping with Hyperactive and Aggressive Children. New Horizon Press Publishers 1984,21.

years, there have been numerous successful treatments in the area of Attention-Deficit Hyperactivity Disorder. The first form of treatment is individualized psychotherapy. Psychotherapy is a treatment where the group leader helps the child identify their problems and feelings in an appropriate manner. In fact, this may be a setting where other children with the same diagnosis may give the child feedback on different ways to stay focused. One form of psychotherapy that is offered to a child during a time of stress and anger is preventive therapy.[69] This form of psychotherapy helps target feelings before the child acts out and loses control of a situation. Another form of psychotherapy is supportive therapy which gives the child an opportunity to process their feelings with a supportive person, who can help the child cope with immediate issues.

The next form of psychotherapy is play therapy. This is where "the therapist gets clues about who's bothering the child from the way he/she plays with a doll family or other toys."[70] Play therapy and structured play therapy are very helpful to hyperactive children; because they are able to understand they can only play with one thing at a time and/or can only participate in the play activity chosen. The last form of psychotherapy is "child psychoanalysis, which aims to restructure a child's personality." [71] Most psychotherapy attempts to give the child insight into his/her personality traits and into his/her relationship with

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[69] Diane E. Papila and Sally Wendkos Olds. A Child's World *Infancy through Adolescence.* Fourth Edition. McGraw-Hill Book Co. (New York, 1986), 453.

[70] Ibid.

[71] Ibid.

others. "Child psychotherapy is usually much more effective when combined with some forms of counseling for the parents."[72]

The second form of treatment shown to be effective with hyperactive children is family therapy. This form of treatment not only helps the client, but assesses the structure of the family and its problems. Many times the child may act out more to draw attention to the family. With hyperactive children it is equally important to include parents to educate them and help them understand the disorder. Another form of treatment therapy helpful to these children is behavior therapy behavior modification. This form of therapy is a treatment approach using principles of learning theory to alter behavior. In ADHD children its focus is to change, condition, or shape the child's behavior, and reward them for making positive changes. In fact, behavior modification is one of the many effective forms of therapy in the field. Through the implementation of behavior modification many forms of token economy/reward programs are formulated. Token economy rewards the hyperactive child immediately after a positive choice, or a good deed. For example, for a reward for positive behavior a child may receive points toward day passes, movie time, free game time, toys or special treats. Behavior Modification show ADHD children they can alter their behavior and make positive choices of thinking before they act. Behavior Modification also teaches the child how to reward themselves for a job well done.

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[72] Ibid.

The final form of effective therapy with hyperactive children is drug therapy. This is a form of therapy where the treatment techniques include administrating medications to alter the cognitive and behavioral aspects of the child. There are numerous forms of medications that have been used to treat hyperactivity; but the most successful are ritalin, cylert, and pemolie. Out of this group ritalin is proven to be the most prescribed and most successful in young children, it's so popular with the younger children because of its calming effect and ability to help the child think clearer. Ritalin is the leading medication to treat the symptoms of hyperactivity in America today. It seems now that maybe children are being over diagnosed and more prescriptions for the medication are being given to children maybe needing other forms of treatment. Cylert and Pemoline are other forms of medications that are used with hyperactive children. Research shows that children have different body chemistries, which is why these three well known medications are used interchangeably to alter the symptoms of the child.

Although these are identified as effective medications, there are other numerous medications that these children are forced to take in order to find one that works best with their body chemistry. In another article entitled, Attention-Deficit Disorder: Born To Be Hyperactive? written by Dr. Alan J. Zametkin, new research not covered by other authors of "medication holidays" is discussed. These medication holidays are nothing more than a time that doctors experiment with medications to see what combination work best for the child. The child is

used as a "guinea pig" and forced to endure long and short term side effects of the medications before having to return to school on new medications. These medication holidays include: Spring Break, Thanksgiving, Christmas, New Years, Good Friday, Summer Vacation or other times in which time off from school is given.

Medications to treat ADHD appear to increase arousal and alertness of the brain by increasing the supply of chemical neurotransmitters like dopamine, norepinephrine and serotonin.[73] Research supports the fact that "medications are usually not sufficient in themselves to solve the many problems associated with hyperactivity."[74] On one hand, stimulant medications can be an important part of the child's treatment program; but they should be used with other therapies.

From the increased diagnosis of ADHD children, there is an increasing demand to significantly inform the public of the side effects of the medication prescribed, and the abuse that is taking place with the administering of these medications. Without sufficient attention given to this area there is a possibility of death from: combining of medications along with over-the-counter drugs, such as cough medicine. Some of the side effects include long-term seizure disorders, dependence of medications, overdoses, stunting of growth, heart problems, kidney problems, eating disorders, skin disorders, rashes, blurred vision, uncontrolled movements of the body and the list continues.

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[73] Ibid. p. 51
[74] Ibid.

What is Play Therapy

To have an understanding of what play therapy represents, the word play must be defined. Play is defined by Zanden in Human Behavior as voluntary activities that are not performed for any sake beyond themselves.[75] The Psychiatric Dictionary by Campbell defines play therapy as a method of treatment that in general corresponds to the psychoanalysis in adult psychiatry, the difference being that the child expresses himself and reveals unconscious material to the therapist by means of play rather than by verbalization of thoughts.[76]

Effectiveness of Play Therapy on ADHD Children and Other Children in the Latency/School Age Stage

Play in the eyes of all children is a time to express themselves, run, skip, jump and a time where they can act out their fantasies. Young girls play with dolls, doll houses, have tea parties, and mimic the behaviors exhibited by their mothers and other adults. They learn to clean house, and socially interact with others early in life . Boys on the other hand, normally play with trucks, footballs, climb trees and only interact with the same sex in the latency stage of child development. It seems as if normal functioning children integrate play into their

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[75] James W. Vander Zanden. Human Development. Fifth Edition. Mc Grae-Hill, Inc. (New York, 1993),286.

[76] Robert Jean Campbell M.D. Psychiatric Dictionary. Seventh Edition. Oxford University Press. (New York, 1996),750.

lives easily. However, children who have been abused in some form have difficulty playing, and expressing themselves in the presence of others.

It has been shown there are methods being implemented where non-abused and abused children can benefit from play therapy; because it offers a relationship where the child has expanded boundaries and feels complete. Play therapy is incorporated in many cases where the child is having difficulty expressing him/her feelings through play in different settings. In some situations if there is suspicion of abuse play therapy is a method used to have the child recapture that time and place. Play therapy is also recommended if the family shows signs of dysfunction or if the child is continuously exhibiting inappropriate behavior in a school setting.

Usually children who have been abused and neglected which is the case of many of these children show inappropriate behavior, as a method of reaching out for help. Play therapy is used with these abused, hyperactive and neglected children to help them release their anger and feelings of guilt. When play therapy is incorporated its fundamental goal is to provide corrective and reparative experiences. Play therapy teaches the child appropriate interactions that engender a sense of safety, trust, and a building of the self-esteem. The healing power of play cannot be underestimated; if given a nurturing safe environment, the child will gravitate toward a reparative experience.

In the latency stage/ school age, play therapy can be used a method of treatment in sexually-abused children. Play therapy can be used to help children

express how and by whom they may have been abused. Play therapy can also help the child recreate the traumatic event through play. The event can be recreated through the usage of dolls, pencils, paper, crayons, yarn—anything can be used to help the child express themselves. In some cases with young boys, trucks and miniature "action figures" are used by the child to show the abuse. The use of paint is highly recommended, as a medium for the child to express himself; it is important to pay close attention to the colors being used. In play therapy and art therapy colors signify different things, such as cries for help. Play therapy through implementation has been shown to be very effective with abused children. Play therapy with abused, neglected and hyperactive children is an area where insufficient evidence has been given as a clinical approach to early childhood intervention of abuse.

Overview of the Major Theoretical Orientations

The form of theory that has been chosen for this thesis is the Cognitive-Behavioral Theory. Cognitive-behavioral theory considers exclusive focusing on only behavior of cognition. "Three important assumptions underlying cognitive behavioral approaches to psychotherapy have been supported by research over the past decades: (1) that cognition's mediate behavior, (2) that a relationship exists between cognition's and emotional arousal so that the way in which a person labels or evaluates a situation, on the basis of his or her expectancies and assumption, affects that person's emotional reactions to it, and (3) that

particular patterns if maladaptive cognition's are characteristics of specific psychological disorders".[77] One of the major objectives of cognitive therapy is to help clients to gain a new perspective on their problems. Clinicians provide clients with new opportunities and hope the client will be able to work through their problem. In this theory clients are taught how their cognition can help to explain the etiology and maintenance of their maladaptive emotional and behavioral responses. "Once clients have grasped these points, they are more likely to be motivated to engage in therapeutic interventions".[78] The course of cognitive-behavioral theory is to provide therapy that alternates between interventions designed to correct faulty cognition's, and interventions designed to increase behavioral competencies.

"In cognitive-behavioral approaches, targeted problem behaviors are specified precisely in operational terms, while seminal cognition's related to the problem behaviors are identified; since they function as stimuli in controlling the dysfunctional overt behaviors".[79] In this type of theory it is important to select techniques that will encourage the client to adapt and place in their daily routine. "Therapists use devices such as modeling and behavioral and covert rehearsal during the therapy session to teach the client new coping skills".[80] Cognitive behavioral therapies are active and goal oriented, incorporating educational

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[77] Janet M. Zarb, Ph.D. Cognitive-Behavioral Assessment and Therapy with Adolescents. Brunner/ Mazel. (New York, 192), 5.

[78] Ibid.p.4

[79] Ibid. p. 5.

[80] Ibid.

methods such as agenda setting, structure, clarification, feedback, reflection, practice and homework.

This particular theory was chosen because not only does its intervention affect the cognitive aspect; but it affects the behavioral aspect also. The intervention chosen for this study, play therapy affects a child both cognitively and behaviorally. Play therapy helps the child identify the problem area and create other alternatives to cope with the problem. For example, impulsive is one of the key factors to the disorder ADHD. If a child can be taught to think, then their behavior can be changed. In the majority of Piaget's play therapies the child has an opportunity to think, then react to the situation at hand. In the majority of all play forms the cognitive behavioral theory is applied because the child is being taught and re-modeling the taught behavior during appropriate times.

Definition of Terms

Attention-Deficit Hyperactivity Disorder (ADHD): symptoms include inattention, excessive motor activity and impulsivity. Hyperactivity is manifested in restlessness and poorly organized excess activity that is hazard inconsistent and lacking in clear goal orientation. Other symptoms include learning deficits such as: dyslexia, perceptual-motor deficits, defective coordination, lack of

response to discipline and antisocial behavior. The syndrome usually appears early in life (in infancy or by the age of 7 years)[81]

Attention-Deficit Disorder: similar to ADHD, but instead of hyperactivity and impulsivity there are apathy, daydreaming, and insufficient motivation in pursing goal directions activities such as school, work, household tasks, or employment.[82]

Cognitive-behavioral therapy: applied to a variety of procedures, with the common distinguishing feature of simultaneous endorsement of the importance of the role of both cognitive and behavioral process in shaping and maintaining psychological disorders, and the application of empirically-based cognitive and behaviorist procedures to alter dysfunctional response patterns.[83]

Play therapy: a method of treatment that in general corresponds to the method of psychoanalysis in adult psychiatry, the difference being that the child expresses himself and reveals unconscious maternal to the therapist by means of play rather than by verbalization of thoughts.[84]

Statement of the Hypotheses

1. This paper has been formulated to show there is a significant change of negative behavior in a Attention-Deficit Hyperactivity child who is exposed to play therapy.

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[81] Robert J. Campbell. Psychiatric Dictionary. Seventh Edition. Oxford University Press. (New York, 1996), 72.

[82] Ibid.

[83] Janet M. Zarb Ph.D. Cognitive-Behavioral Assessment and therapy of Adolescents. Brunner/Mazel, Publishers. (New York, 1992), 1.

[84] Ibid. p. 750.

CHAPTER 3

METHODOLOGY

Research Design

Single systems design was chosen to observe the client in his innate state, with him having knowledge that he was being observed. The research was designed to objectively observe his behavior in different types of play therapies and document behavior changes. To protect the confidentiality of this subject and the facility, the client will be identified by the alias of Jarvis.

Sample

The data for this research was collected from one Attention-Deficit Hyperactivity Disorder diagnosed child living in a private, long-term mental health institution in Atlanta, Georgia. The child chosen for this study represented a population of ADHD/Latency-aged boys with multiple issues that formulated their diagnoses. This patient was chosen for this study, because the present interventions being administered did not seem to be affective. The child was on the verge of giving up, and reported many times that he felt hopeless. This patient was in dire need of another chance of someone helping him to cope with his disorder, including being taught ways of appropriately approaching females. In order to acquire confidential records concerning the client, the Team Leader of his unit was contacted, and informed of the study. Since the child was a ward of the state of Georgia, the child was allowed to participate in the intervention. The subject

participated in this study for a total of eighteen weeks. The patient's baseline data was collected for five weeks where the child was introduced to the study, basic information was collected, and an assessment was done to identify what behaviors he exhibited that can be altered through play therapy. The intervention was applied for eight weeks where play therapy was used to help the patient cope with anger, develop coping mechanisms, control impulsive behavior, inattentiveness, hyperactivity and other problems associated with Attention-Deficit Hyperactivity Disorder. The child was required to attend play therapy sessions once per week for sixty minutes. The play therapy sessions included symbolic play, practice play, games with rules and construction play. The follow-up phase lasted for five weeks where the information from the baseline, intervention and evaluation phase were compared. Information was collected on a goal attainment scale to observe him in individual session, psychotherapy, and in the "minu" (the sitting area on the unit). Each time that the patient showed one of the symptoms on the goal attainment scale, he received a mark. At the end of each day the score was calculated and an average was calculated. This occurred in each phase of the study and was compared in the end.

Data Collection Procedure (Instrumentation)

The dependent variable was ADHD, and is defined as a child who is no longer able to stay focused on a task in these settings: 1) home, 2) school, and 3) social settings. The proposed outcome of the subject's behavior was measured on a

goal attainment scale, with the scale ranging from 0-10. A copy of the facilities rating scale is provided. The target service of play therapy showed that it was a productive and natural method to help the child focus. From the exposure of play therapy; the scale was scored according to the subject's change of behavior.

Hyperactivity, was defined as the subject's inability to focus on task (i.e., follow directions given the first time, pay attention), interact positively with others, (use appropriate language, communicate with others), and inability to control impulses (thinking before reacting, establishing poor boundaries between people, threatening, fighting). Hyperactivity itself can be controlled by medications, but the goal of this paper is to show how it can be controlled with the use of play therapy.

The data was collected for a total of eighteen weeks and was placed on a scale to observe the changes in the client's behavior. The first scale monitored the client in the baseline phase. The second scale monitored the client while being introduced to the intervention. The follow-up phase evaluated the study and determined how the client benefited.

Data Analysis

The data obtained from this research was explained descriptively. Statistical analysis was performed, to ensure reliability of data collected. The research was employed the bivariate analysis to explain the relationship between the dependent variable ADHD and the independent variable play therapy.

CHAPTER 4

PRESENTATION OF RESULTS

The objective of this study was to identify the effectiveness of play therapy on a latency diagnosed child with Attention-Deficit Hyperactivity Disorder. The study covered a total of eighteen weeks. Within those eighteen weeks the patient chosen for the study was administered four different forms of play therapy. In those administrations the patient received two sessions of each phase, with different activities.

The subject responded poorly on target behaviors during the baseline phase. As the client was introduced to different types of play his behaviors improved on the goal attainment scale. During the third session the patient had a seizure from the medication and consequently, responded poorly on target behaviors for that week. It can be interpreted that the seizure had some barring on his behavior change. The null hypothesis of this study was rejected, because the client responded positively to the study, even though he knew that he was a participant in the study.

In this section each session was described in detail to get an understanding of the intervention and the clients response. The exercises for this experiment were chosen by the client and researcher of the experiment. It was important to have the client involved. Some of the exercises chosen were needed for the client to learn to mimic and understand to better use later. This

particular client has the diagnosis of ADHD along with, being charged as a sexual offender.

Baseline Phase

Session I: Client and I met today for our first session. The goal of this session was to establish rapport. I introduced my self as a MSW student at Clark-Atlanta University. I informed him that I had graduated from Bethune-Cookman College in Daytona Beach, Florida. Before beginning the MSW program, I had worked in a private mental health partial program that had a program specifically for latency aged boys. I informed him that in this facility I gained experience in behavior modification, different point systems, art therapy, therapeutic groups, music therapy, and play therapy. From this facility I also gained a lot of experience with different disorders, especially Attention-Deficit Hyperactivity Disorder. "Jarvis" disclosed information about himself. He is a 10 year old African-American male who had recently moved to the area with his mom from Korea. The patient shared that his mom was a nurse in the Armed Forces and his father was in the Armed Services. His parents had been divorced for an unspecified period of time. Jarvis shared his goal in life was to be successful, either by being a basketball player or a doctor. The patient stated that he was encouraged to be a doctor, because he had such a high IQ". The goal for today was accomplished. Session time: 60 minutes.

Session II: Client and I met today for our second session. The goal of the session was to introduce and educate him on his diagnosis of Attention-Deficit Hyperactivity Disorder. The patient was asked to share what he knew about ADHD. Jarvis responded that it's a disorder in kids and adults that make you not be able to pay attention. You go and do things that you haven't thought through, and then you get into trouble. The patient was asked if he could share anytime when he wasn't paying attention or did things without thinking them through. The patient was hesitant, but shared a time when he grabbed a young lady in her chest. Jarvis shared that he had a history of doing things on impulse and being punished for them later. Patient was asked to describe what he was thinking before, during and after he grabbed the young lady. Jarvis responded with "I don't know Miss Dee." Patient was told that he was correct with what he thought the disorder meant, but that it was a little more complicated than that. Patient was told that he has the disorder, and was not alone; that there was hundred of other kids just like him with the disorder. He was told that his stage of development is where the majority of children are diagnosed. Jarvis was also told that although it exists in females, there's a higher percentage in males. He was told that ADHD was traditionally treated with medications and that they were proven to be effective. He was also told that their are other forms of treatments, such as behavior modification, proper dieting, art therapy, psychotherapy, family therapy, individual sessions, and play therapy. No longer do children with this disorder have to be given only one alternative for its treatment. The patient

shared that in his facility he receives medications, psychotherapy twice per week, one individual session, and one family session every other week. Jarvis was educated to the long and short term effects of medications. Some of the medications can cause: dizziness, long and short term seizures, tics, vomiting, high blood pressures, etc.

Goal for today was accomplished. Session time: 60 minutes.

Session III: Client and I met today for our third session. The goal for todays session was to identify some interventions, that are already being used to help the client. Jarvis reported that he had a seizure this past weekend. He was asked to share his experience. He shared he was playing basketball with his peers and he remembered trying to get up from the ground. He shared he had been refusing to take his medication; Wellbutrin, because it made him feel light-headed. He shared that he had complained to the nurse and was told he would be reported to the physician for refusing his medication. Patient is unable to share what was occurring while he had the seizure. He shares he can only report what he was told that he was doing. Patient was very confused and afraid during the session. Today's session was spent observing him, and processing the events surrounding his seizure. Goal for today was not met.

Session time: 60 minutes.

Session IV: Client and I met today for our fourth session. The goal for today's session was to discuss interventions presently being used and the intervention he will be exposed to in this study. The first intervention that we discussed was

medications and how effective he felt that they were. Presently, Jarvis is on Pindendolol 10, tid, Clonidine 0.1 mg 8a,12p, 0.2mg 8p, Cylert 112.5 mg qd, Benadryl 75 po q hs, PRN Vistail 75 mg, and PRN Desyrel 50 mg. We discussed each medication, the reason that he is taking it, and if the physician feels that it is effective. Pindendolol is used to control his aggression and irritability, and the physician feels that the medication is partially effective. Clonidine is used to control his aggression and rage and it is found to be partially effective. Cylert is used for his Attention-Deficit Hyperactivity Disorder diagnosis and has been found to be partially effective. Benadryl is used to control his agitation and is partially effective. PRN Vistail is used to control his depression and the effectiveness is unknown to the physician. PRN Desyrel is used for agitation and anxiety and is found to be effective by the physician. The medication Wellbutrin was discontinued; because of his seizure was used to control his Insomnia and was said to be effective. We discussed next the intervention of psychotherapy; Jarvis felt that it is helpful to be in a group with other peers with the same and/or similar disorders. The discussion of the intervention was brief because before becoming a part of this study, the patient reported having inconsistent individual sessions. Since they were inconsistent he found them not helpful, and did not know what to say in them. The final discussion of his interventions was on family therapy. The patient shared that he finds it very supportive for his mother and to work with him through their problems without yelling, and for her to be able to understand more about his

disorder. At the end of the session we briefly discussed play therapy as being the intervention of this study. The patient was informed that play is a child's natural way of exploring and naturally working through issues. Today's goal was accomplished. Session time: 65 minutes.

Session V: Client and I met today for our fifth session. The goal of this session was to educate the client on the stages of play therapy and what we will be incorporating in each stage. For this phase the tradition stages of Piaget will be included along with an extra stage that is associated with his work. Piaget's first category of play is practice. In this stage the child adapts to rules. Session VI and VII have been devoted to practice play. The second category of play is symbolic play this is where make believe, or imaginary people or situations come into play. Sessions VIII and IX have been devoted to symbolic play. The third category of play is games with rules where children work together so that the game will be continued. Session X and XI have been devoted to this category of play. The four category that will be used is construction. This type of play is seen as a midpoint between work and play. Sessions XII and XIII have been devoted to discuss this type of play. Today we ended our baseline phase. In our baseline phase information was collected on his history, his knowledge on his diagnosis, his knowledge of his interventions and his knowledge of play. In this phase a lot of information was collected, as well as a lot of educating the client was accomplished. Today's goal was accomplished. Session time: 60 minutes.

Intervention Phase

Session VI: The client and I met for our sixth session and our intervention phase began. The client was very eager to begin. The type of play used was practice play. We went to the court and played basketball. Because he practiced playing basketball he was able to refine his skills. The focus of this type of play is for the client to "fine tune" his skills. For the first thirty minutes Jarvis played by himself shooting three-pointers, slam dunks, free throws and lay-ups. For the last twenty-five minutes he played with peers who had come out to participate in recreational therapy. By him practicing he was able to be more compatible with peers. The last five minutes we processed what occurred today and what would happen in next week's session. The goal for today was accomplished. Session time: 60 minutes.

Session VII: The client and I met today for our seventh session. The goal for today's session was again practice play. Since the client liked to jump rope, this was chosen as today's exercise. For the duration of the session Jarvis and I showed each other different ways to jump rope. We skipped rope, tied the rope to a pole and played double dutch, played one dutch, sling rope, snake rope and horse rope. Jarvis already knew how to jump but through this exercise he learned new games and had a lot of fun. The last ten minutes we discussed the next type of play we will use in the study. The goal for today was accomplished. Session time: 60 minutes.

Session VIII: The client and I met today for our eighth session. The goal for today's session was to teach the client appropriate ways to approach young females (role playing). Patient came in today's session very "giggly" and silly-acting; it was assumed that this is a difficult and embarrassing topic for the client. Client was asked to share different times, positive and negative, when he approached females inappropriately and what happened. When he finished he had only identified negative ways of approaching young ladies. He shared that because he was impulsive, he was "pushed" to do things at the spur of the moment and not think of the consequences. With the information he had given we went back and identified positive ways he could have handled the situations. A male staff member was asked to participate in today's session and role play with me in appropriate non-verbal ways to show he was interested in me.

Client was asked to participate in the role playing as the observing friend of the male staff member. We played through three scenarios of non-verbal appropriate approaches:

The first scenario was in a mall where the male staff member smiled at me. The second scenario was in a grocery store where the male staff member opened the door for me and winked his eye. The third scenario was in a church where the male staff member nodded his head and glared at me at a distance. Although there was no talking in each role play, the client was able to see how the approach was appropriate each time. Although this phase may appear appropriate, client has other issues related to him pushing and having no

respect for female boundaries. This role play was actually very helpful to him, since he is a growing young man and a little more advanced than some of his peers. The goal for today's session was accomplished. Session time: 75 minutes.

Session IX: The client and I met today for our ninth session. The goal for today's session was to continue the role modeling, but to learn appropriate ways to approach females through communication. In today's session Jarvis was asked to share different times when he has verbally approached females and what happened. Once again Jarvis identified only negative memories. A male staff member was asked to come into today's session and model different situations where Jarvis could communicate with females his age appropriately. The scenario depicted staff pretending to pick up a young lady's book off the floor that she had dropped. Staff modeled how Jarvis should pick up book and say "Excuse me miss, you've dropped your book. By the way my name is Jarvis and I'm a student here." The second scenario showed him approaching a young lady that he admired. Staff modeled introducing himself and stated, "I must tell you something, you're a very nice looking young lady and I would like to have lunch with you tomorrow." Patient appeared more focused in today's session and was able to go back and remodel the behavior of the staff member. The last few minutes we discussed this was the ending of our symbolic play stage, where we used role modeling. Next week we will begin the third type of play, entitled games with rules. Goal for today was accomplished. Session time 65 minutes.

Session X: The client and I met today for our tenth session. The goal of today's session was to play the feeling, thinking and knowing games. This was our first session of games with rules phase. The game played was a therapeutic board game with rules and I encouraged the patient to answer questions dealing with his feelings, his thinking, and his knowing. After the patient rolled the dice, he moved his piece five times and picked up one of the feeling cards. Jarvis shared his feelings that he thought the game was stupid. He was encouraged to give the game a chance, and was told that without him I couldn't play. Jarvis became re-interested when he found out that I had to answer the same question that he did. The purpose of this game is to place him in past and present situations that require him to think, and identify different ways of handling the situation.

Goal for today was accomplished. Session time: 60 minutes.

Session XI: Client and I met today for our eleventh session. The goal of today's session was to play another game with rules entitled Uno Dominos. This is a game played like Uno (the card game), and like dominos, combined. The object of this game is to play all of your dominos before your opponent does. Jarvis was very excited and focused. During today's session we played the game three times. I processed with client that this would be the ending of the play phase games with rules and we would begin construction play in next week's session. Goal for today was accomplished. Session time: 63 minutes.

Session XII: Client and I met today for our twelfth session. The goal of today's session was to play with Lego building blocks. This session entered our final phase of play therapy: construction. This type of play encourages work and play to be used parallel. By using Legos, Jarvis was able to use his creativity to build a bank building. Jarvis had to work at putting the windows in and planning the foundation while having fun at the same time. Goal for today was accomplished. Session time: 55 minutes.

Session XIII: Client and I met today for our thirteenth session. The goal of today's session is to finish our session with the Lego building blocks. During the session Jarvis built numerous things. We discussed that today would end our fourth play phase, and we would be going into the evaluation phase during the next few weeks. Today's goal was accomplished. Session time: 62 minutes.

Evaluation Phase

Session XIV: Client and I met today for our fourteenth session. Today we began our evaluation phase of the intervention. Today's goal was to discuss sessions VI-IX. The patient reported he liked both sessions, and that in a sense he learned something different in each stage. He reported that by having two sessions of each phase made it easier for him to understand the different meanings of each one. Goal for today was accomplished. Session time 55 minutes.

Session XV: Client and I met today for our fifteenth session and we discussed session X-XIII. Patient shared that he liked only one of the phases in this session. Patient was unfocused during today's session. Patient was reminded that we would soon begin preparing for the termination of the study. Jarvis was in a hurry to end today's session. Goal for today was accomplished. Session time: 60 minutes.

Session XVI: Client and I met today for our sixteenth session and he was asked to identify his favorite activity and his favorite phase of the study. Jarvis identified the activities of role modeling and Lego building as his favorite activities. Jarvis identified the symbolic play as his favorite phase of the play study. I informed the patient that we only had two more sessions to meet and the study would be over. Session time: 60 minutes.

Session XVII: Client and I met today for our seventh session. Patient was asked to share how he felt the study went. Patient was angry in today's session and refused to discuss why. Jarvis walked out of today's session. Session time: 30 minutes.

Session XVIII: Client and I met today for our eighteenth and final session. Jarvis quickly apologized for his behavior on last week and shared he was angry: because he wouldn't be participating in the study any longer. I informed him of the result to the study that his behavior had went from a high 9 to a 1.3 over the past eighteen sessions. Jarvis was reminded that his confidentiality

would be protected, and no one would know that he participated in this study. I thanked Jarvis for his participation. Session time: 60 minutes.

CHAPTER 5

CONCLUSION

The objective of this study was to identify the effectiveness of play therapy on a latency aged child with ADHD. Although the patient had a seizure during this study, it only encouraged patient to pursuit the intervention. The patient's behavior was observed in the on-site school, in psychotherapy group, in individual sessions and in the "minu" with peers. It was interpreted that the client benefited from all phases of this study. Patient's behavior went from a 9.3 in the first week, to a perfect 10 during the week of his seizure (the maximum score for abnormal behavior) to a 1.3 at the end of the study.

Although some of his behaviors increased and decreased, his average score was lower than it was when the study began. Although the client has other issues that encourage his diagnosis, he was able to take what he learned in play therapy and use it in his personal life.

Limitations of the Study

Within this study there existed many limitations. The conductor of this study is only present in the agency for three days out of each week. Because of this, the conductor could only observe the effects of the study on these three days. The scores for this study were higher on those three days because the patient was consistently observed. The scores obtained by the agency were taken by untrained, non-regular staff members that were not heavily concerned

with the study. Because many of these staff members work whenever they are asked, they didn't know what behaviors to observe. The charting on each patient is done at the end of their shift, at which time the staff may have forgotten what each child did. Many times symptoms that were stated on the goal attainment sheet required, the staff to write out the situation. The staff at times was too tired to write anything, so the behavior went unreported.

Also, since there were so many children in the program, it was difficult to keep an eye on anyone and remember exactly what they did. The agency formulated a treatment team every four to five weeks depending on the month, and whether the child had private insurance or not. . Because of this the scores may be higher or lower than observed by the facility. The treatment team—which is composed of the doctor, nurse, social worker, recreational therapist, educational therapist and behavioral specialist—make the rating scores on the goal attainment scale according to what they think it should be, not always what the child is exhibiting. This was also a time during this treatment team assembly that they decide to change the primary symptoms of the child. The program was set up to where they could only identify ten symptoms at a time.

The medication response was required to be rated by the doctor, but from what has been observed this is rarely the case. It was pretty much the decision of everyone else on the treatment team to rate whether or not the medication was effective. Many times the child used the same medication for weeks at a time, and showed no improvement. Instead of stopping the medication and

trying another form of intervention, the treatment team continued to use the same treatment. Several times when the client was being observed, staff didn't report that the client had taken a personal time out. The scores of the facility and this researcher are totally different because of changes occurring in the program.

Suggested Research Directions

For future social workers desiring to make a difference in the lives of children with Attention-Deficit Hyperactivity Disorder, the direction that could be taken is one that at least considers play therapy along with other updated interventions that don't use medications as the only alternative, or the base of the intervention. Future social workers could only allow their clients to take medications when there is no other alternative. Research could be done to make sure that these children receive the best treatment and are able to live happy and healthy lives.

Implications for Social Work Practice

There are many who come into social work just to work in case management, counsel, and/or generally help those that are in need of services in daily living. In this area there are so many other areas of need that aren't touched, but need equal attention. Social workers are forced to maintain many requirements. Summarizing and defining any implications for social work

practice should be handled carefully. When using alternative methods to treatment, for example, social workers are empowering the client and playing the role of an educator. In particular, the area that deals with Attention-Deficit Hyperactivity Disorder is one of thousands that needs attention by clinicians to educate families and communities.

By social workers being educated in this field other forms of therapy will be implemented other than medication therapy. By educating the community the social worker can help children from being exposed to harmful medication and identify healthy, natural methods of handling the same situation. Social workers are sorely needed in the area of children and mental health. Someone should advocate for these children and educate their parents. It has been shown that with the use of play therapy comparable results can occur as compared to medication therapy.

Social workers in this field of mental health should receive as much practice as possible to sharpen their book knowledge skills. Every social worker isn't going to be right all the time; but through practice the social worker will become more confident and well rounded.

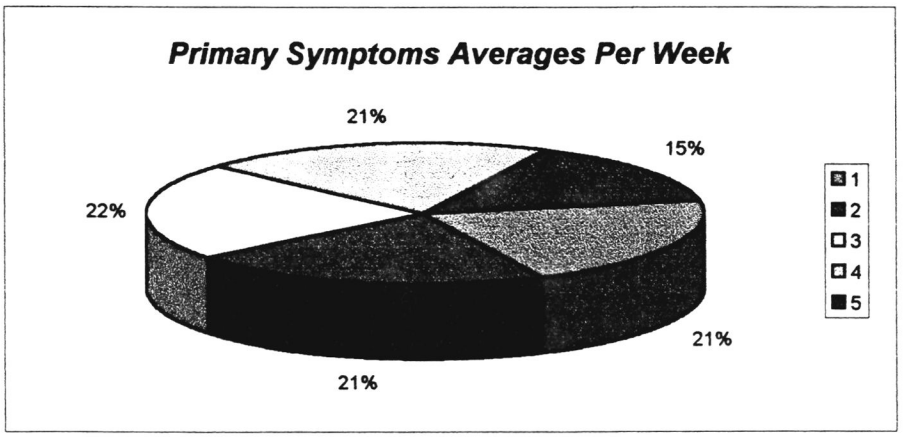
APPENDICES

Appendix A

Primary Symptoms/ Problems	Week 1	Week 2	Week 3	Week 4	Week 5
Defiant	10	10	10	9	8
Argues with Adults	10	10	10	9	6
*Verbal Aggression	8	9	10	10	6
Inattentive	9	9	10	9	5
Impulsive	9	9	10	9	6
Hyperverbal	8	9	10	10	4
Hyperactive	10	10	10	10	8
Anxiety	9	9	10	10	8
Provokling/Threatening	10	10	10	8	8
Intrudes on others/Poor Boundaries	10	10	10	8	8

Averages	9.3	9.5	10	9.2	6.7

Special Procedures/Precautions					
Seclusions	0	0	0	0	0
Very Close Logs	0	0	0	0	0
Constants	0	0	0	0	0
One -on- Ones	0	0	0	1	1
Time-Out Self-Iniated	0	0	0	3	3
PRN Medications	1	1	3	0	0

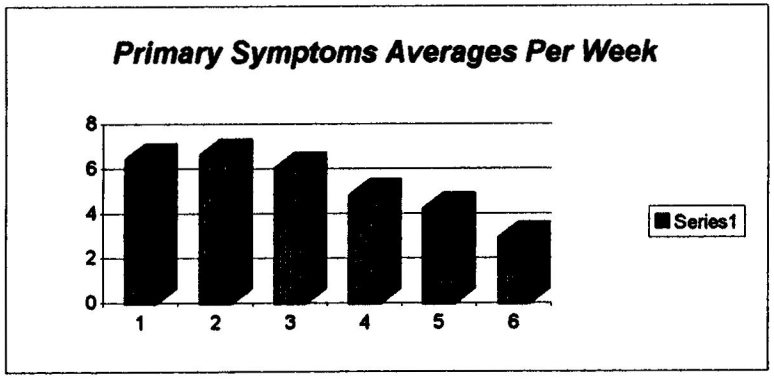


Baseline Phase

Primary Symptoms/Problems	week 6	week 7	week 8	week 9	week 10	week 11	week 12	week 13
Defiant	8	8	7	5	6	5	5	4
Argues witrh Adults	6	7	7	5	5	4	3	3
*Verbal Aggression	8	7	7	5	5	4	4	3
Inattentive	6	7	6	6	6	4	4	2
Impulsive	6	6	7	5	6	5	2	0
Hyperverbal]	5	6	5	5	3	2	1	0
Hyperactive	5	5	5	5	5	2	2	1
Anxiety	5	7	5	5	4	3	2	0
Provoking/Threatening	8	7	6	2	2	0	0	0
Intrudes on other/Poor Boundaries	7	6	5	5	0	0	0	0

Averages	6.4	6.6	6	4.8	4.2	2.9	2.3	1.3

Special Procedures/Precautions								
Seclusions	0	0	0	0	0	0	0	0
Very Close Log	0	0	0	0	0	0	0	0
Constants	0	0	0	0	0	0	0	0
One -on- Ones	1	1	2	1	1	1	1	1
Time-Out Self-Iniated	2	1	1	3	1	0	1	0
PRN Medications	0	0	0	0	0	0	0	0

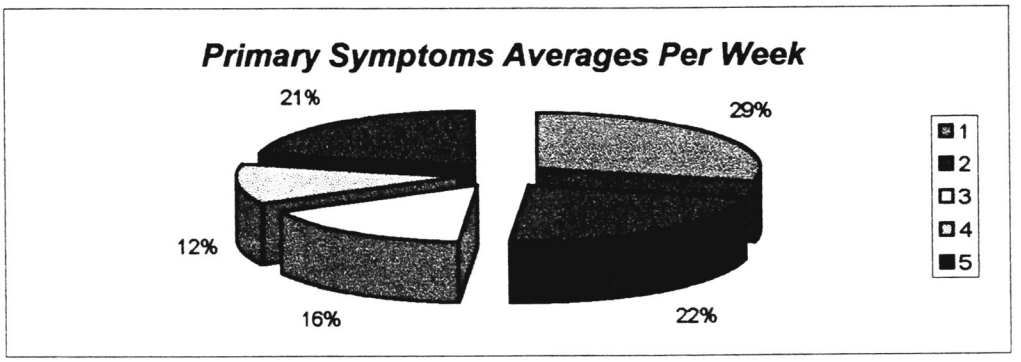


Appendix C

Primary Symptoms/Problems	week14	week 15	week 16	week 17	week 18
Defiant	4	4	2	2	4
Argues with Adults	3	3	3	3	3
*Verbal Aggression	3	3	3	3	4
Inattive	2	2	1	0	0
Impulsive	3	3	1	1	0
Hyperverbal	0	0	0	0	0
Hyperactive	5	2	2	0	3
Anxiety	2	0	0	0	2
Provoking/Threatening	0	0	0	0	0
Intrudes on others/Poor Boundaries	0	0	0	0	0

Averages	2.2	1.7	1.2	0.9	1.6

Special Procesures/Precautions					
Seclusion	0	0	0	0	0
Very Close Logs	0	0	0	0	0
Constants	0	0	0	0	0
One-on- Ones	0	0	1	1	1
Time-Out Self Iniated	2	1	1	4	3
PRN Medications	0	0	0	0	0



Evaluation Phase

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